

## Forensic Laboratory Application for Satellite Laboratory Licensure

### I. General information

<input type="checkbox"/> Initial Application <input type="checkbox"/> Renewal <input type="checkbox"/> Survey <input type="checkbox"/> Change in Certification Type <input type="checkbox"/> Other Changes ( <i>Specify</i> ) _____			MARYLAND FORENSIC IDENTIFICATION NUMBER _____ <i>(If an initial application leave blank, a number will be assigned)</i>		
FACILITY NAME			FEDERAL TAX IDENTIFICATION NUMBER		
EMAIL ADDRESS			TELEPHONE NO. ( <i>Include area code</i> )	FAX NO. ( <i>Include area code</i> )	
FACILITY ADDRESS — <b>Physical Location of Laboratory (Building, Floor, Suite if applicable.)</b> <i>Fee Coupon/Certificate will be mailed to this Address unless mailing address is specified</i>			MAILING/BILLING ADDRESS ( <i>If different from street address</i> )		
NUMBER, STREET ( <i>No P.O. Boxes</i> )			NUMBER, STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
NAME OF DIRECTOR ( <i>Last, First, Middle Initial</i> )			NAME OF DIRECTOR/ SUPERVISOR OF SATELLITE LABORATORY ( <i>Last, First, Middle Initial</i> )		
NAME OF QA MANAGER ( <i>Last, First, Middle Initial</i> )			<b>For Office Use Only</b> Date Received _____ Application Approved _____ Check Number _____ Amount _____		

**II. Hours of Laboratory Testing** *(List times during which **laboratory testing** is performed in HH:MM format)*

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

**III. Personnel**

Indicate the number of individuals employed within the laboratory \_\_\_\_\_

Indicate the number of individuals who are subject to proficiency testing in each discipline:

*(Includes technical support personnel and trainees)*

**Drug Chemistry** \_\_\_\_\_

**Pathology** \_\_\_\_\_

**Trace Evidence** \_\_\_\_\_

**Toxicology** \_\_\_\_\_

**Biology** \_\_\_\_\_

**Firearms/ Toolmarks** \_\_\_\_\_

**Odontology** \_\_\_\_\_

**Entomology** \_\_\_\_\_

**Questioned Documents** \_\_\_\_\_

**Latent Prints** \_\_\_\_\_

Indicate the number of individuals who are not subject to proficiency testing \_\_\_\_\_

*(Managers, Clerical, Etc.)*

**IMPORTANT:**

**Please have all personnel who direct, supervise, and perform forensic analyses complete the supplemental Statement of Qualifications Form included with this application. These forms must be submitted with the license application, otherwise the application will be considered incomplete. (Extra Copies of the form can be made for submission)**

#### IV. Director Affiliation with Other Laboratories

If the director of this laboratory serves as a director for additional laboratories that are separately licensed, please complete the following:

MD Forensic Lab License Number	Name of Laboratory

#### **ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION**

I/ We certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a forensic facility subject to the provisions of Health-General Article, Title 10, Subtitle 51. Annotated Code of Maryland, and to the regulations adopted thereunder by the Secretary of Health and Mental Hygiene.

<b>SIGNATURE OF OWNER/ DIRECTOR OF LABORATORY</b> <i>(Sign in ink)</i>	<b>DATE:</b>
<b>SIGNATURE OF CO-OWNER/ QA MANAGER OF LABORATORY</b> <i>(Sign in ink)</i>	<b>DATE:</b>
<b>SIGNATURE OF DIRECTOR/ SUPERVISOR OF SATELLITE LABORATORY</b> <i>(Sign in ink)</i>	<b>DATE:</b>